ATTEMPTING a MERGER:

Reorganizing Health Services in Los Angeles County

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The underlying socioeconomic causes of the Watts riots of 1965 were not recent developments. The conditions of poverty that led to the riots had existed in this urban ghetto and others for years. But the turmoil in the streets focused public attention on the conditions and dramatized the problems. In the report on health resources and services in the Watts area, prepared for the Governor's Commission on the Los Angeles Riots, which investigated the causes of the riots, medical care was singled out as one of the most serious deprivations of the poor (*1*):

> Conclusions on the health services available to the people of the Riot Area are not difficult to draw. Medical resources—personnel and facilities—are far below American norms in volume and quality. Public programs for general disease prevention, for treatment of the poor, for mental health, for the health of school children are relatively well developed, but their impact is far below the needs, and they are inhibited by the conventional restrictions of governmental action in a free enterprise medical setting. Organized private health actions supported by voluntary donations, insurance, or industry, are weak.

Second class health care for the poor has been well documented in every large urban center in the United States and in many rural areas. It proceeds from private sector inadequacy and public sector intimidation. From the most thorough recent analysis of health services in Los Angeles County, it was concluded that the county health system suffers from inaccessibility, complexity, inadequacy, inflexibility, remoteness from the people, and fragmentation (*2*). Revelation of the low level of health care came in a precedent-shattering suit brought by 70 medical interns and residents against the county hospital for inadequate medical treatment of the poor (*3*). This action echoed longstanding concerns and complaints of the public and of hospital personnel about the impersonality, delays, and conditions in county hospitals.

Recent studies of health services have stressed the problem of fragmented and conflicting jurisdictions resulting in gaps and overlaps in the services provided to the consumer (*4–5*). Outmoded organization of the health system is cited as a

basic cause of deficient health services. Roemer (*6*) calls for comprehensive rather than categorical health programs and for the coordination of health efforts. Little guidance is offered, however, on how coordination can be brought about in the face of competing local constellations of power, each with different views of the ideal form of health coordination. Kaufman (*7*) has written a valuable review of the literature on the political element in the organization of health services.

Merger of public health agencies is a common proposal for increasing coordination at every level of government although the difficulties connected with such mergers remain to be explored. This review of the work of the Los Angeles Health Services Planning Committee in arriving at such a proposal underscores the important questions of how mergers can be accomplished and how effective they may be in correcting the shortcomings of fragmented health care.

This paper is a case study of an attempt to improve health services for the poor in Los Angeles County, where more than $265 million, excluding the imposing expenditures under Medicare and Medicaid, was spent by public agencies for health services in 1968–69. In 1967 a blue ribbon health services planning (HSP) committee, created by the Los Angeles County Board of Supervisors, began deliberations on the role the county should assume in health and how it should be organized to carry out its role most effectively. The 21-member committee included many of the key people in the Los Angeles health services power structure: the directors of the health-related county departments, deans and faculty members of the local medical and public health schools, and leaders of the county medical society and of voluntary agencies.

The committee was originally referred to as the Egeberg committee, after its first chairman, Dr. Roger O. Egeberg, then dean of the University of Southern California School of Medicine. It later became known as the Bauer committee when Egeberg became Assistant Secretary of the Department of Health, Education, and Welfare, and the new dean of the University of Southern California School of Medicine, Dr. Franz Bauer, joined the committee to replace him and was elected chairman. This committee became a focal point of attempts to design a more adequate system of delivering health services. Part of the effort involved a recommendation to coordinate the county's health organization by merging existing county departments involved in health activities as a necessary administrative device to effect comprehensive rather than fragmented health services.

I studied the workings of the Los Angeles County Health Services Planning Committee during 1969 and 1970. Participants in the health activities were interviewed, and documents were analyzed. The Los Angeles experience illustrates some challenges encountered in attempting to improve health services and the conflicts that surround such changes. It can also add to knowledge of the health field, and more generally, of the innovation process in organizations and social systems.

Background of the HSP Committee

The Los Angeles County government is typically referred to in political science textbooks as one of the best examples of a modern urban county, marked by efficient provision of urban services and a high level of professionalism (*8*). The county covers 4,083 square miles, includes 77 cities, and has 7 million people. It is governed by a five-man board of supervisors, chosen by districts in nonpartisan elections for 4-year terms. Power is highly centralized in the board, since the only other elected officials are the district attorney, the sheriff, and the assessor. Since 1938, the supervisors have appointed a chief administrative officer (CAO), whose office has been powerful because of its responsibility for the budget and administrative supervision on behalf of the supervisors (*9*).

Local forces. The health functions of the county have always been fragmented among different departments, but the actual divisions have varied. In 1969 four departments had the major health responsibilities: hospitals, public health, mental health, and public social services. The department of hospitals, with a budget of about $230 million in 1968–69, operated eight facilities including general hospitals, rehabilitation centers, and long-term care facilities (*2a*). The department of public health operated 23 health centers and 28 subcenters with a budget of $23 million; the department of mental health, with a budget of $16 million in 1968–69, had five inpatient facilities, 10 rehabilitation services, and 29 outpatient services. The department of public social services determines eligibility for public assistance and Medi-Cal (California's Medicaid) benefits, and provides medical-social consultation for welfare recipients.

These departments provide a large share of public medical care but, in addition, public funds

through Medicare and Medi-Cal finance a significant part of the care provided by the private sector. The fragmentation of health services is thus heightened by the responsibility of the private sector for providing about 70 percent of health care received by the residents. Mere recital of the activities of the four major health-related departments in the county indicates the extent of the problem that the HSP committee was deliberating.

The organization of health services that existed in 1969 had evolved from a long series of prior reorganizations. The two most important preceding ones will be discussed; both helped bring about the creation of the HSP committee. Before 1964 two major public health departments existed in the area—the Los Angeles County Health Department and the Los Angeles City Health Department. Each provided a full range of public health services in different geographic areas but with overlapping tax sources. On July 1, 1964, however, following a series of commissions and studies dating back to 1929 urging the merger of the city and county health departments (*10*), the city relinquished its health functions to the county. Proponents of consolidation said that it would eliminate duplication of staffs and functions in two health departments, remedy the tax inequity for city residents, and provide better quality service. The Sherwood-Cloner study (*9*) is an interesting analysis of why consolidation was finally accomplished.

After the consolidation, a variety of problems remained to be worked out: changes in programs, personnel, and space arrangements. The cleavages that developed during the debate over consolidation constituted an important factor within the new department (*9a*). It was anticipated that further scrutiny of the services of the merged department would be necessary to realize the promise of improved services. Thus the shockwave from the consolidation was one local force that led to the formation of the HSP committee.

The second major reorganization in the health services of the county concerned its hospitals. Before November 1966 they were part of the department of charities, which also included the bureaus of public assistance, medical social services, licensing, and adoptions. When this department was split in 1966, three separate departments were created: hospitals, public social services, and adoptions.

No thorough study seems to have been done of this reform. One reason given for the change was the large size of the department of charities. With a budget of $516 million, it had about 40 percent of the county's employees. But others say regrouping of similar functions was the reason rather than organizational size. (A memorandum, dated July 1, 1966, from the CAO to the board of supervisors concerning the "charities department reorganization," shows that both size and similarity of functions were listed as reasons for the reorganization.)

Regardless of motivations, in 1967 three of the four major health-related departments in the county had recently undergone major reorganizations. These changes in organization reflected discontent with existing health services and led to heightened visibility of problems in the resulting organizations. Thus previous reorganizations (namely, merger of the city and county health departments and creation of separate departments of hospitals and public social services) served to stimulate a new attempt at reform through the HSP committee.

National forces. A variety of nationwide forces converged with local forces in causing the Los Angeles supervisors to set up the health services planning committee. The national trend of rapidly rising medical demands and costs resulted in increasing loads on public medical facilities throughout the United States and a changed relation between private and public sectors. When combined with the general economic plight of local governments (*11*), these conditions meant that the quest for economy and efficiency took on even greater urgency.

Related to rising medical costs and loads were changes in the organization and operation of health services throughout the United States. Medicare and Medi-Cal are the most obvious examples of change brought on by national legislation, but in the private sphere there were changes, such as the growth of private health insurance, group practice, and comprehensive health plans. These developments changed the setting within which local public health efforts were operating.

A third national force was the growing emphasis on the need for comprehensive health services to overcome the inadequacies of existing fragmented programs. This awareness was embodied in two Federal laws: the Heart Disease, Cancer, and Stroke Amendments of 1965 (Regional Medical Programs), Public Law 89–239, and the Comprehensive Health Planning Act of 1966, Public Law 89–749. P.L. 89–749 required States to de-

velop comprehensive plans for the provision of health services and authorized areawide planning agencies that could receive Federal grants to assist them in their planning. This act seemed to offer a source of new funding for the health activities of local governments.

These national trends gave impetus to Los Angeles County officials concerned with further examination of the health services affected by prior reorganizations of county health functions. The influence of national forces may be seen in the charge given by the CAO to the HSP committee. He mentioned each of the national developments just listed. In referring to the Comprehensive Health Planning Act, he said (*12*):

> It is our thought that this Committee may be able to serve at least as a nucleus of a Los Angeles County area-wide planning group and may be able to qualify for a planning grant under the Act to conduct comprehensive planning for this County. Certainly, a share of the 62½–70 million dollars per year available for service grants is extremely important to this County, and we feel we must do everything possible to meet the Federal criteria for participation by development of a comprehensive plan.

Formation of the HSP Committee

The board of supervisors approved the creation of the HSP committee on April 4, 1967. This action was proposed to the supervisors by the CAO's office as part of a three-phase plan for review of county health services.

The first phase in this plan was a management audit of the consolidated health department, carried out by the CAO's staff beginning March 1966. The second phase was a program review of the health department, to be conducted by an outside consulting group. Both steps were called for by the health department's advisory commission and its director in a letter to the supervisors, which was referred to the CAO's office for study January 11, 1966.

The management audit was carried out first, and the report to the board in March 1967 specified the third phase of the review of health services. It called for the immediate creation of a special committee, the HSP committee, to assess the proper role of the county in the field of personal health services without being limited to existing departmental structure.

It is important to note that the HSP committee was not proposed by any existing line department or its advisory group, as was the management audit and the program review, but resulted from the CAO's own management audit. The CAO apparently saw the committee as a vehicle for responding to the diverse pressures on the supervisors—the nationwide pressures from new legislation, new trends in health service organization, rising medical costs, and the demands for coordinated medical service as well as local pressures generated from the merger of the city and county health departments and from splitting the department of charities. The CAO's office felt that the special committee would help bring about essential major reorganization of health functions.

The importance which the CAO attached to the HSP committee is reflected by the sequence of events. Even though the program review of the health department was included in the 1966–67 budget, the CAO decided to push ahead first with the committee. Only after it was in operation did the CAO arrange for the American Public Health Association (APHA) to conduct the program review of the health department. When the Community Health Action Planning Service of the APHA began working on that review in October 1968, part of its charge was to coordinate its efforts closely with the HSP committee, which then had existed for more than a year.

The CAO traditionally has recommended to the board of supervisors several different types of special study committees: a joint interdepartmental committee, an outside consulting group, or a citizens' committee. To assess the role of the county in health, the CAO decided to recommend a citizens' committee. Interdepartmental committees require a willingness to cooperate among the concerned departments—a willingness that did not exist on this issue. No agreement could have been reached among the departments on the appropriate consulting group, so a citizens' committee was the choice. A blue ribbon citizens' committee would allow the involvement of the key decision makers concerning health in the county and would give them equal status with county government personnel. The CAO selected 16 members for the citizens' committee, and each of the five supervisors appointed one member, bringing the total membership to 21.

HSP Committee Activities

The first meeting of the health services planning committee took place on June 28, 1967. Three task forces were set up:

1. The task force on district boundaries and coordination was to consider the boundaries of

districts within the county used by health-related departments and to make proposals for coordinating them.

2. The task force on organization was to study the number, types, and organization of departments providing health services

3. The task force on public-private relationships was to analyze the interface between the public and private health sectors

No drafts of task force reports appeared until 1969. The time lag was due primarily to the CAO's failure to assign adequate staff to the project. The committee did not have enough priority at that time to merit full-time staff assistance. Some committee members were so disturbed about this problem that they threatened to complain publicly that the supervisors were not sincerely concerned about health. The CAO's office then provided more staff.

Between June 1967 and April 1969, however, events were taking place that would shape the recommendations of the committee. First, county plans to apply for funds from the Office of Economic Opportunity for a southeast neighborhood health center became enmeshed in disagreements over sponsorship, and chances for funding appeared increasingly dim. Second, the thinking of the APHA program review staff about the need for a new system of comprehensive health service centers influenced the HSP committee. (There was significant interaction between both groups, and influence went in both directions; as the APHA report states (*2b*): simultaneous consideration of closely related problems has been beneficial for both undertakings.) And then one supervisor, in an action that surprised the CAO and other committee participants, moved on February 25, 1969, that the CAO and the departments investigate creation of a comprehensive health services program in south central Los Angeles, in the vicinity of Slauson and Main (his district). On April 15, 1969, following a favorable report from the CAO, the supervisors voted to include funds for a center at Slauson and Main and asked the CAO to develop plans for comprehensive health service centers at other locations in the county.

This early approval of comprehensive health service centers markedly changed the environment within which the committee was operating. Originally, the chairman of the task force on organization had hoped that the report would propose a system of comprehensive care, linking neighborhood comprehensive health service centers for primary ambulatory care, hospital-based special diagnostic clinics, and hospitals for inpatient care into a vertically integrated pattern. This system would end the existing artificial separation between preventive services provided in district offices of the health department and curative services provided in distant hospitals. The approval of a major part of the comprehensive system by the supervisors gave a big impetus to the chairman's intentions, but it also required the task force to grapple more than it might otherwise have done with the issue of the organization of the comprehensive system. Thus the supervisors' mandate is an interesting example of the cart successfully leading the horse.

Beginning April 1969, the task forces' actions accelerated and became intermingled with the CAO's implementation of the supervisors' directive to plan for the comprehensive centers. Furthermore, the deliberations of the task force on organization became the focal point of the committee.

The task force on boundaries presented a relatively noncontroversial report at the end of April. It urged that service modules based on census tracts be used by all county departments to achieve boundary unification and uniform data collection. But these recommendations assumed that departmental structures would not be basically changed, and this assumption was being vigorously questioned by the task force on organization.

In the spring of 1969, an interim report of the task force on organization was circulated. The first two recommendations supported the supervisors' plans to establish a health delivery system that would link hospitals, hospital-based special diagnostic clinics, and community-based comprehensive health service centers and do this first in south central Los Angeles, including the Slauson and Main center. The third recommendation was the most controversial: that "the county should, through a progression of organizational changes, reorganize its personal health delivery services into a single organization." The report explained that this proposal was reached after considering four alternative organization plans for the local level (an add-on plan, an interdepartmental plan, a regional personal health services plan, and a countywide area health services plan) and three alternative proposals for total departmental organization (autonomous departments, agency structure, and a single health services department).

The proposal was based on the last alternative in each of the two lists of alternatives—a countywide area health service plan, run by a single health services department. The report then suggested a series of steps by which this goal could be reached. A crucial interim step came to be known as the dual administration plan. It proposed that the comprehensive health service centers be administered jointly by the departments of hospitals and health (hospitals being responsible for the clinical staff and quality of medical care and health for administration of the centers) until the single health services agency could be established. This dual administration proposal was defended as consistent with the approach of the APHA's program review.

Four persons were primarily responsible for the contents of the task force's interim report—the chairman of the committee, who was from the University of California (Los Angeles) School of Public Health, the CAO staff member, the department of hospital's staff member, and the chairman of the health department's advisory commission. These men delineated the alternatives and thus had a major influence on the final recommendations of the task force on organization. The county departments of health and mental health were invited to draft the interim report, but their representatives did not participate. The CAO asked the health department for more contribution to the deliberations but was told the department was too busy. In contrast, the department of hospitals assigned a staff person to work closely with the HSP committee and the task forces. This action helped the department of hospitals to influence HSP decisions.

It is significant that all three departments most directly concerned concurred with the first two recommendations in the interim report of the task force on organization. The departments agreed on the paramount need for the new comprehensive system of care. Disagreement naturally arose over how it should be run and who should control it. All initial departmental reactions to the third recommendation in the interim report were negative. On June 16, 1969, the director of hospitals opposed the creation of an entirely new department of health services. He favored retaining both the departments of hospitals and health but realigning their functions so that hospitals would be responsible for all personal health services—those services delivered by or under the direction of a physician to an individual patient—and health for communitywide public health services. In line with this preference, he opposed dual administration health centers for ambultatory patients, feeling that the centers should be under the direction of a general hospital.

On June 24 the director of mental health also stated his opposition to the creation of a new department of health services. He said that there was no justification for the "agglomeration of individual departments with clearly spelled out individual missions and bases of community interest and support into a large 'super' department." He went on to say that there was a "leap of logic" between "the acknowledged desirability of bringing health services closer together at the local level and the questionable desirability of bringing them together centrally in the form of a single health service agency." Instead, he favored interdepartmental coordination.

On June 30 the health officer presented views that remarkably paralleled mental health's views. He opposed a single health department and supported the dual administration of the ambulatory care centers. He said this could be possible by means of interdepartmental coordination and "any department that says that such coordination will not work is indicating its lack of desire for coordination." (The implied criticism of the department of hospitals was obvious.)

After these initial negative reactions, a variety of informal conversations occurred that resulted in reversal by all three department heads of their positions on the desirability of a single health department. Several factors led to this change. The consensus among the CAO staff members was that the interdepartmental coordination favored by health and mental health was not feasible; thus dual administration of health centers was not feasible either. The CAO staff mentioned examples of dual administration projects, such as those in alcoholism and drug abuse, that had failed and emphasized that coordination would become increasingly difficult during the period of rapid change foreseen in the health field.

The department of hospitals was the first department to support the CAO's reasoning. It had opposed dual administration from the start and so was closest to the CAO's position. It was relatively easy to change from talk about realigning functions—with the implicit assumption that many of the health department functions properly belonged to hospitals—to the creation of a new department with newly defined functions. Hospital

personnel played a large part in convincing the other two departments to favor the creation of a new unified health agency. The argument was that if interdepartmental coordination failed, the CAO would step in and actually run the departments, especially since a CAO staff member had the experience to qualify for this responsibility. To prevent this outside interference, health professionals were urged to create one health organization that would allow them to make the major health decisions themselves on a sound basis.

In a departmental position paper of September 22, 1969, the health department no longer objected to the creation of a unified health department. Its concern was with the administration of the comprehensive centers during the interim period when the new department would not yet be operating. The health department repeated its support for dual administration of these centers. Mental health's position paper of September 23, 1969, continued to oppose the unified health department. The position paper of the department of hospitals, also dated September 23, stated its support of a new health agency and then made a proposal which insured that mental health would not continue active opposition. The department of hospitals proposed that mental health not be merged into the new department "for the present."

As a result of these modifications in thinking, the task force on organization reached agreement at its September 25, 1969, meeting that "a single health service department should be recommended as the ultimate organization of county health services departments." Thus the proposal contained in the interim report was retained in the final report even though originally it was opposed by the three departments most closely concerned. The key factor in eliminating the opposition apparently was the realization by each department that it could not get undisputed control over the personal health activities and it therefore would be better to give control to a new organization rather than risk having one of the other departments or the CAO get control. The minutes of the September 25 meeting hint at this reasoning as follows: "After discussion it was concluded that it would be better not to turn over administration of personal health services to any of the three existing departments, with their present responsibilities and institutionalized concepts. It would be better to turn it over to a new personal health service organization."

Throughout all the negotiations, however, the department of hospitals—the largest and most powerful of the three departments primarily involved—assumed that it would be able to continue its preeminent position in any new arrangement that emerged. It organized its participation on the HSP committee to insure this dominance. Hospitals, as stated, assigned a full-time staff person to the committee and the department's representative was committee chairman. Hospitals worked hard to hold onto the chairmanship after Egeberg resigned. (The department of hospitals, through its main hospital, is closely identified with the University of Southern California Medical School. It lobbied for Bauer's election as chairman even though he had not previously been on the committee and was reluctant to become chairman because he was too busy.)

At the September 25 meeting, the task force on organization also made some recommendations about the organization of the new department and phasing during the interim. The new department would have three major subdivisions:

1. Comprehensive personal health services—organized by area, not by type of facility.
2. Community health services—health education, environmental health, epidemiology, and so on.
3. Administrative services—fiscal matters, statistics, training, planning, and evaluation.

The phasing would first integrate administratively all physicians in each comprehensive health service center with the physicians in the hospital linked to each center. Until completion of the organization of comprehensive personal health services by area, the supportive staff in hospitals would remain under the administration of the department of hospitals and the supportive staff in the comprehensive health service centers would remain under the administration of the department of health. Thus the idea of dual administration of health centers was kept alive temporarily.

The interim report of the task force on public-private relationships was completed in August 1969, but it did not receive as much attention as the report of the task force on organization. The public-private task force supported the organization proposals and recommended that the county enter into contractual arrangements with private health service organizations of physicians in order to staff county comprehensive facilities.

At a meeting of the HSP committee on September 29, 1969, the recommendations on a new

health service delivery system were unanimously accepted, except the proposal for a unified department of health services. Three people connected with mental health voted against this provision on the grounds that important parts of the mental health program would be lost if it were merged into a larger organization. A fourth dissenting vote was based on the opinion that the new organization would be too large, just as the department of charities had been.

The committee members did not have before them a copy of the final report at the September 29 meeting. They voted to approve the task force reports with the understanding that the CAO's office would have the responsibility of writing up the final report of the Bauer committee. The report was written during October and November 1969 and circulated to members for their comments in December and January. The committee never met again to discuss the final report. The CAO contacted the members individually and made minor changes to fit their suggestions. The CAO apparently felt that nothing would be gained by reconvening the committee, and the tenuous agreement might disintegrate. Further, the CAO staff member assigned to the committee had resigned, and the committee was again short of staff.

While the HSP committee was deliberating, the APHA group was engaged in an intensive program review of the health department. Dr. Malcolm Merrill and his staff, along with 20 consultants, were doing an indepth analysis of the department's activities within the framework of the county's total health service system. They analyzed thoroughly the programs and problems and made recommendations for improvement in specific programs of the department and in the overall county health service system. In a fully documented report, they concluded, like the HSP committee, that a unified department was necessary to implement an effective system to meet the people's needs for comprehensive health services in the neighborhoods where they were living.

On February 24, 1970, the reports of both the HSP committee and the APHA's program review staff were presented to the board of supervisors. Dr. Bauer made the formal presentation of the committee's final report, and Dr. Merrill presented the APHA report. The HSP committee's recommendation for a unified health department was worded as follows (*13*):

> The County should go on record immediately as being committed to a phased reorganization of the functions of the Health, Hospitals, and Mental Health Departments into a new Department of Health Services as soon as it can be accomplished.

After statements from the audience and discussion among the supervisors, the board of supervisors voted 5 to 0 to approve in principle the recommendations of the committee and to refer them to the CAO, who would, together with the concerned departments, advisory bodies, and community health groups, study the proposals and suggest a plan of implementation.

Thus it might seem that the merger of separate health departments and the provision of coordinated care in Los Angeles County was assured and that the chronology of the HSP committee's activities was completed. Not at all! Many of the key committee members harbored serious reservations about the proposed merger and had been maneuvering ever since the appearance of the interim report of the task force on organization to strengthen their positions in the battle over the merger, a battle in which the supervisors' vote on February 24 represented only one of the opening skirmishes.

Political Influences on HSP Committee

Consideration of the political factors influencing this attempt at innovation indicates the complexities entailed in changing the organization of health services. Every respondent to the author's inquiry agreed that the major obstacle to change in the organization of health services in Los Angeles County was jealousy among the departments. Mistrust between the department of health, the department of hospitals, and the department of mental health was more than mere organizational conflict. It was also a conflict between different professional orientations and different political philosophies (*14*). Each departmental staff felt that its mission and its ability to serve the public were in jeopardy. Each department was uncertain about its role in a society that was beginning to view health as a right for every citizen.

This conflict was articulated clearly in statements made from the audience to the board of supervisors at their meeting on February 24, 1970. The directors and the advisory committees of the departments of health and mental health expressed concern over the creation of a new department of health services. They outlined different reasons for their concern, but behind the words was the implicit assumption that the new organization would downgrade their departments'

missions and their professional identities. This fear was voiced explicitly by the chairman of the health department's advisory commission, who said, in effect, that everyone knew that the department of hospitals was trying to grab the whole thing. (At this remark there were many nods and smiles of agreement among the supporters of the departments of health and mental health, who had turned out, in marked contrast to the absence of anyone from the department of hospitals.)

The struggle among the three departments was obvious in their initial reactions to the interim report of the task force on organization. After they reluctantly agreed to the creation of a new health organization, the battle switched to the details of the phased development of this agency. A key aspect of this phasing was control over the comprehensive health service center already approved by the supervisors. By looking closely at negotiations over the control of the center at Slauson and Main, one can see the forces at work and the strategies employed. (The term "strategies" does not necessarily mean that the persons were aware of using a particular approach. Rather, the term is used analytically—the observer sees a pattern in events that the participants may or may not have intended or been aware of.)

Starting in August 1969, the CAO held meetings of a health team charged with implementing the supervisors' April decision to create a comprehensive health service center at Slauson and Main. The team was composed of representatives from the departments of health, hospitals, mental health, and public social services and the CAO. Thus planning for one component of the comprehensive health service system was underway before planning for the new unified organization, which will eventually be responsible for the system, really was started.

On October 16, 1969, the CAO gave the supervisors a progress report on the team's plans for the comprehensive health service center at Slauson and Main. The report stated that the department of hospitals would be responsible for planning the total component of personal health services at the center. This appears to be a modification of the organization task force's temporary dual administration plan, which gave health the responsibility over all personnel at the center, except the physicians, and also a modification of the APHA's interim dual administration plan. Department of health personnel felt that this modification proved that the department of hospitals was trying to take over the center completely and would ignore the need for preventive medicine and community involvement. Personnel of the department of hospitals felt that the department of health was purposely ignoring previous agreements made by the team that hospitals would be responsible for physicians and supporting staff in the personal health services at the centers.

It was apparent that each department was trying to establish as much control as possible at Slauson and Main to strengthen its bargaining position when the details of the phased development of the new department were worked out. The conflict is aptly illustrated in the descriptions that proponents of health and hospitals have given as to the relation between the comprehensive health service centers and the hospitals: the department of hospitals sees the centers as satellites of the hospitals, as extensions of hospital outpatient departments; the department of health sees the hospitals as backups for the ambulatory care centers and the centers as district health offices expanded to include curative services.

In the midst of the conflict between the departments, the CAO had been playing a key role. The strategy had been to avoid open conflict. Note that the CAO avoided controversy over the exact wording of the final report by never calling a meeting to approve the report. The CAO could work out disagreements in private with the interested parties. This same strategy was at work in asking the supervisors to agree in principle to one department, leaving the CAO free to develop informally the details of the plan. This approach was spelled out in an October 14, 1969, memorandum that the CAO sent to the members of the health team planning the centers at Slauson and Main, indicating that the CAO was urging the Bauer committee to limit itself to "broad policy guidelines recommendation to the Board" and to leave out some of the specific organizational details specified in the organization task force's interim report—apparently the dual administration plans. This omission was facilitated by the fact that the CAO staff wrote the report and followed its own advice.

Since the merger negotiations were private and not in writing, it is easy to see how the paranoia could build up. Each group thought the other was violating the spirit of some agreement. Each group charged the others with lobbying actively to get the CAO on its side. Meanwhile, each group strove diligently to mobilize all the supporters it

could find for its own lobbying efforts. For the departments of mental health and health, this strategy meant activating their advisory groups to use their ties with the supervisors. For example, in October 1969 the health department's advisory commission obtained agreement from the board of supervisors not to consider the Bauer report before the APHA report. The commission believed that the APHA's dual administration proposal provided important safeguards for the preventive and community aspects of health that might be obliterated by the CAO's plans for the phased development of a single health agency.

In his statement to the board on February 24, 1970, the director of the health department used another familiar tactic. He charged that the HSP committee was not representative because no consumers were included as members. (A cynic might ask if the health department had raised this problem sometime earlier during the 2½ years of the committee's life.) The CAO, well aware of the departmental antagonisms, concluded that it was better to let them smolder privately rather than to air them publicly and make the merger even more difficult. If innovation had to await full agreement, action might well be prevented.

In summary, each department's desire to protect its position led it first to oppose merger as a means of coordination. Then when merger appeared less distasteful than other alternatives, such as subordination to the CAO, each agreed in principle to a merger but continued to pursue its particular interests during detailed planning for merger. These conflicting interests had contributed to fragmented health services before formation of the HSP committee, had precluded departmental cooperation as a means of innovation, and had necessitated formation of a citizens' committee to secure needed changes. These same conflicting interests shaped the committee's deliberations and recommendations. And they can influence the success of the proposals and the final evaluation of the committee's effectiveness in coordinating Los Angeles health services by merging the health organizations.

Epilogue

It would be convenient if the effectiveness of the HSP committee could be determined now. One would like to point to the committee's work as an example of how coordination can be stimulated despite competing local constellations of power. But such a conclusion is premature.

Nine months after the supervisors approved in principle a merger of the health departments, no further major steps toward that end had occurred. One participant commented euphemistically: "Things have moved slowly." The CAO did not have enough staff time to devote to the health merger because higher priorities had been given to other issues such as elections and the budget. The CAO's main action in health had been obtaining the county counsel's opinion on the necessary legal changes to implement the merger. This effort took almost 1 year.

Meanwhile, the health department's advisory commission held a series of community meetings to solicit reactions to the HSP committee proposals. This move was interpreted by many as an attempt to arouse support for the health department's reservations about the merger. A frequent complaint at the meetings was that the community had not been consulted by either the HSP committee or the APHA program review staff. Even if enlightened professionals succeed in improving health services by mergers, the services may not compensate for the lack of voice felt by certain segments of communities. These segments are demanding a voice, saying they will not cooperate in the services unless they achieve their goal (*15*).

A critical written report based on these meetings was presented to the board of supervisors in November 1970. The department of hospitals was hesitant to push too hard for action, thinking the board would prefer to see the opposition to the merger subside before taking further action. Participants were also aware that the selection of a successor to the CAO would influence the priority that that office gives to the merger.

More progress was apparent in the plans for a comprehensive health service center at Slauson and Main. The health team planning the center continued to meet throughout 1970. Open conflict over control of the center was postponed by concentration on plans for program and physical plant rather than administrative structure. For planning purposes, the departments agreed on a division of work. The department of health planned for community health, the department of hospitals for personal health, and the department of mental health for its field. A decision on administration may never be necessary because the facility will not be operating for at least 3 years. If the fate of the merger is decided by then, it will determine the control of the center at Slauson and Main. Thus while there was progress on this cen-

ter, it no longer seemed to be accelerating progress on the merger. But in various other areas of the county, such as in Venice, Harbor, and the North East Valley, community groups were pushing to develop centers for comprehensive health services or networks of ambulatory and inpatient services. Some observers feel that these developments in the county will be at least as important in improving the coordination of health services as the "downtown" effort to merge departments.

Significance of HSP Committee

Even though it is too early to evaluate the effectiveness of the HSP committee, this study of the committee's formation and deliberations illuminates some problems connected with mergers, which are a popular device for reforming institutions such as hospitals and governmental agencies.

The first problem is how to stimulate innovations in existing organizational structures. In Los Angeles, forces outside the existing departments were important catalysts. Nationwide problems of inadequate health services and national legislation helped create a receptive environment. Then a series of local reorganizations of health departments made problems in Los Angeles County's health delivery visible. Responses by the CAO and the board of supervisors to these pressures were the immediate stimuli for action. The mechanism for action, a blue ribbon citizens' committee, was also external to the departments. Thus the entities to be merged did not bring up the idea of reorganization; it was initiated from the outside but, since the pressures were strong, the departments could not block the attempt.

The second problem is how to proceed with reorganization. The HSP committee did not avoid departmental conflicts. The departments were not able to prevent the formation of the committee, but their efforts to protect their interests shaped its deliberations. Study of the HSP committee supports the generalization that dominant forces get control of reforms (*16–17*). In Los Angeles the department of hospitals had the upper hand in all negotiations. Not only was it the largest and most powerful department, but its resources were organized to influence the committee. One wonders whether the HSP committee could have recommended a departmental merger if the department of hospitals had opposed the idea.

Even though the approach to innovation by the blue ribbon citizens' committee could not circumvent existing departmental conflicts and power relationships, it did succeed in getting the departments to agree on a merger—an accomplishment many had thought was impossible and which none of the departments had originally wanted. Thus even though dominant forces get control of reforms, in Los Angeles this outcome did not mean total control. The same outside forces that simulated a reform attempt were also considered during the deliberations. Due to these outside forces, which made it obvious that health services had to be improved, the departments were unable to resist the merger idea; they could see that some change was inevitable and chose the alternative least undesirable to them. The committee also slightly counteracted the power of the department of hospitals owing to the efforts of certain members to see that the departments of health and mental health did not get completely lost in the merger proposal. Thus a new entity, the HSP committee, created a new force in the local health game (*18*). Even though this force was limited by the preexisting environment, its proposals were more than a mere affirmation of the status quo. The citizens' committee was able to capitalize on favorable trends and achieve an outcome not previously attained—an authoritative determination that merger is desirable. The supervisors' acceptance of the committee proposal creates leverage for change and increases the possibility that a merger will occur.

All the participants believe that a merger will occur eventually, even though progress toward it will be slow. But a third problem raised by this study is how much difference a merger will actually make in the quality of health services in Los Angeles County. What kind of health services will result? Will they be coordinated and comprehensive? Will merged departments deliver to the people at the grass roots? Will a change in the administrative structure have a significant effect on output? A growing body of evidence warns against a naive faith in institutional tinkering. Just as powerful forces can dominate the reform process, they tend to determine the output of the reformed structures.

Even if a health merger is achieved in Los Angeles, it will not necessarily result in coordinated health services. The merger must be implemented in a spirit that makes comprehensiveness possible. Comprehensive services will require new definitions of organizational and professional missions, a reshaping of jobs and powers to integrate preventive and therapeutic functions, and modifi-

cations in existing links with and controls over other organizations, both public and private. Such major changes clearly put a large responsibility on the bureaucrats: their actions will help determine the impact of a merger. Elected officials enunciate policy, often at the suggestion of administrators such as the CAO, but administrators play an equally important part in policy by defining its details in operation. One wonders if the power plays that have marked the discussions about merger will endlessly delay high quality comprehensive care for the poor.

Evidence provided by the experience of the HSP committee underscores the need for further research on mergers. How does the Los Angeles experience, the stimulus and the reform process, compare with other merger attempts? We also need to know more about the actual effect of health mergers. We should try to specify the impact of many types of mergers, taking into consideration the varying environments and adoption processes.

Mergers of health departments do not guarantee improved coordination. Legal mandate and adequate resources are fundamental. Concerned leadership and will are also necessary. But outmoded structures can make coordinated action almost impossible, frustrating the existing potential leaders and discouraging the development of new professionals.

The health services planning committee has begun to grapple with the fragmented delivery of health services in Los Angeles. Its experiences in suggesting a merger of departments provide some guidance, incomplete but significant, to the problems of changing health organization to improve the quality of care for the poor. The needs of people for health services have pushed governmental departments faster than they want to go. The outcome is not yet clear, but it is a matter of life and death. Delays in implementing comprehensive health care for the poor threaten the lives of many persons and the survival of a democratic society.

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